STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185038	A. BUILDING _____ B. WING _____	C 07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PAVILION	401 EAST 20TH STREET COVINGTON, KY 41014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification/Abbreviated Survey was conducted 07/27-30/10; and, a Life Safety Code Survey was conducted 07/29/10. Deficiencies were cited, with the highest scope and severity of a "D". The following AROs were substantiated with deficiencies identified: KY0015101, KY00015102, KY00015103 and KY000015104. ARO KY00015105 was unsubstantiated with an unrelated deficiency identified.	F 000	*This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Providence Pavilion agrees with the allegations and citations listed on this statement of deficiencies. Providence Pavilion maintains that the alleged deficiencies do not, individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by the regulations. This plan of correction shall operate as Providence Pavilion's written credible allegation of compliance.*	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to implement its policies and procedures related to to the abuse of residents. The facility failed to ensure its staff immediately reported allegations of abuse for one (1) of twenty (20) sampled residents (Resident #10). The findings include: Record review revealed Resident #10 was admitted to the facility on 09/19/08 with diagnoses which included, Alzheimer's Disease, Peripheral Vascular Disease, Stasis Ulcer Left Lower Extremity and Arthritis. Interview on 07/27/10 at 3:40 PM, with the Director of Nursing (DON) revealed the facility	F 226	*By submitting this plan of correction, Providence Pavilion does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Providence Pavilion reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action, or proceeding.*	9/13/10

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AUG 20 2010
BY

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	8/20/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 226	Continued From page 1 was made aware of an incidence in which CNA (Certified Nursing Assistant) #3 was assisting CNA #2 with Resident #10's shower on 07/11/10. CNA #2 reported that CNA # 3 washed Resident #10's face rough and sprayed the resident in the face with the hose. Further interview revealed CNA #2 work the following day and did not report this incident, until later in the evening when she told CNA #4. The DON stated CNA #4 reported the incident to her on 07/13/10, and then the facility suspended the alleged perpetrator. Interview with CNA #2 on 07/28/10 at 3:55 PM revealed she witnessed CNA #3 rub Resident #10's face rough and spray Resident #10 in the face. CNA #2 stated she worked all shift on 07/12/10 without informing anyone of the incident. Review of the facility's policies and procedures revealed staff members were to immediately report all allegations of resident abuse to the supervisor or administrator personal.	F 226	F 226 All staff involved in incident with Resident #10 were immediately suspended and then terminated from employment due to not reporting incident in timely manner according to policy. Incident involving Resident #10 was not determined to be abuse and Resident #10 had no negative outcomes. The delay of reporting incident of potential abuse did not affect any other residents. Staff were reeducated on July 13, 2010 by the Director of Nursing and/or Nursing designee regarding the abuse policy which included the reporting of any suspected abuse immediately to the Administrator and/or DON. New employees are educated on abuse and the importance of immediately reporting of incidents to Administrator and/or DON. Employees are given a test to assess retention of this information. Current employees receive annual education on the policy for recognizing and reporting suspected abuse. In order to ensure compliance, Director of Nursing and/or designee randomly question 5 employees regarding the abuse policy to ensure correct and accurate understanding for 4 weeks. Issues identified will be corrected immediately. Results will be reviewed monthly at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring. Identified issues and recommendations will be reviewed with the Medical Director on a weekly basis.	9/13/10
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of	F 280		

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	185036	A. BUILDING _____ B. WING _____	C 07/30/2010

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F 280	Continued From page 2 the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to revise the care plan for one (1) of twenty (20) sampled residents (Resident #7). Resident #7 had a fall with a fracture and the facility failed to revise the plan of care related to the use of a Posey Care bed. The findings include: Review of the clinical record revealed the resident was admitted to the facility on 05/26/1997 with diagnoses which included Profound Mental Retardation, Blindness, Infantile Cerebral Palsy and Epilepsy. Review of the clinical record revealed Resident #7 was readmitted to the facility on 07/12/10 from a hospital stay for surgical intervention of a left femur fracture. Further review of the clinical record revealed the facility assessed the resident as requiring the use of a "Posey Bed" (a restrictive device) to protect the resident's fracture. However, review of the Comprehensive Care Plan dated May 2010, revealed no documented evidence the facility revised the resident's care plan to address the use of the "Posey Bed".	F 280	F280 Resident #7's care plan was reviewed and updated to include the posey bed on 7/29/10. Director of Nursing and/or Licensed Nurse designee conducted a care plan audit for active residents on 7/29/2010. Identified issues were corrected. Licensed Nursing staff was educated on updating care plans on 7/18/10 by the Director of Nursing and/or Licensed Nurse designee. Nursing staff from agency and/or new nursing staff will be educated on the process prior to assignment on the floor. In order to ensure compliance, DON and/or designee will review new orders to ensure care plans are updated to reflect current orders. In addition, (5) random charts will be reviewed per week for (4) weeks by the Director of Nursing and/or Licensed Nurse designee. Issues identified will be corrected immediately. Results will be reviewed monthly at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring. Identified issues and recommendations will be reviewed with the Medical Director on a weekly basis.	9/13/10

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F 280	Continued From page 3 Interview with Director of Nursing (DON) on 07/29/10 at 2:40 PM revealed the care plan should have been updated upon Resident #7's readmittance to the facility, by the nurse who readmitted the resident.	F 280	F 332 Resident #19 had no negative outcomes from receiving Propanolol (medication for blood pressure) 45 minutes prior to when medication was due. Physician was notified of the time variance and no new orders were given. The physician was also immediately notified on 7/28/10 that the resident was receiving Spirolactone 100mg PO daily and the medication was not listed on the physician order sheet for the month of July. The physician wanted the resident to receive the medication and a new order was written. LPN #3 was reeducated on 7/27/10 regarding the proper/allowable time for medications to be administered. LPN #1 was reeducated regarding checking the physician order sheet against the medication administration record. Resident #20 had no negative outcome from receiving Glipizide 5mg crushed. Physician was notified regarding the crushed medication and no new orders were given. LPN #1 was reeducated on 7/29/10 regarding medications that can not be crushed as indicated on the DO NOT CRUSH list, located in the front of the MAR and Pharmacy Policy and Procedure Manual.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure a medication error rate less than five (5) percent (%). There were three (3) medication errors out of fifty-three (53) opportunities. One error was the result of time, one error occurred when a non-crushable medication was crushed, and one error was due to the lack of a valid physician's order. The findings include: 1. Observation, on 07/27/10 at 4:14 PM, revealed Licensed Practical Nurse (LPN) #3 administered Propanolol (medication for blood pressure) 20 milligrams (mg) to Resident #19. Review of the Physician's Orders and Medication Administration Record (MAR)revealed the medication was scheduled to be administered at 6:00 PM. LPN #3 administered the medication one (1) hour and forty-five minutes early.	F 332		

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F 332	Continued From page 4 Interviews, on 07/29/10 at 3:07 PM, 4:27 PM, and 4:30 PM, with Registered Nurse #2, LPN #2, and Kentucky Medication Aide (KMA) #1 revealed medications could be given one (1) hour before or after the scheduled time. 2. Observation, on 07/28/10 at 9:12 AM, revealed LPN #1 crushed Glipizide (diabetic medication) 5 mg and administered the medication to Resident #20. Review of the Physician's Orders and the MAR for July revealed the Glipizide was not to be crushed. Interviews, on 07/29/10 at 4:03 PM and 4:27 PM, with LPN #2 and KMA #1 revealed Glipizide could not be crushed because it was coated for time release. Review of the "Do Not Crush" medication list located in the Narcotic Reconciliation book revealed Glipizide should not be crushed. 3. Observation, on 07/28/10 at 9:41 AM, revealed LPN #1 administered Spirolactone (blood pressure medication) 100 mg to Resident #19. Review of the MAR revealed the Spirolactone was scheduled for 9:00 AM. Review of the Physician's Orders for July revealed no ordered for the Spirolactone. Interview, on 07/30/10 at 10:05 AM, with LPN #2 revealed she had reviewed the Physician's Orders for change over from June to July. She stated she did not realize the Spirolactone was not on the July Physician's Order. She stated	F 332	F 332 Director of Nursing and/or Licensed Nurse designee conducted a medication pass audit for random active residents on 7/30/10. Identified issues were corrected. Licensed Nursing staff was reeducated on 8/02/10 regarding proper timing of medication pass, Medication Do Not Crush list and ensuring monthly physician orders are accurately reflected on the Medication Administration Record. In order to ensure compliance, DON and/or designee will conduct 3 medication pass audits for 4 weeks. Issues identified will be corrected immediately. Results will be reviewed monthly at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring. Identified issues and recommendations will be reviewed with the Medical Director on a weekly basis.	9/13/10

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F 332	Continued From page 5 when she passed medication on 07/02/10 she realized the medication was not on the MAR. The LPN stated she wrote the Spirolactone on the MAR but did not write it on the Physician's Order sheet. The LPN stated the medication error resulted due to her failure to ensure the July orders were complete and accurate. (Cross reference F 514).	F 332	F 431 Medication Carts were audited by DON on 7/30/10. No other medications were found to be without a date or expired. Licensed Nursing staff was educated on 7/30/10 by the Director of Nursing and/or Licensed Nurse designee regarding proper dating of medication and the disposal of expired medications. Nursing staff from agency and/or new nursing staff will be educated on the process prior to assignment on the floor. In order to ensure compliance, DON and/or designee will audit medication charts weekly for 4 weeks. Issues identified will be corrected immediately. Results will be reviewed monthly at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring. Identified issues and recommendations will be reviewed with the Medical Director on a weekly basis.	9/13/10
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431		

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F 431	Continued From page 6 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure drugs were labeled and discarded in accordance with manufacturers's guidelines. The findings include: Observation, on 07/30/10 at 12:15 PM, revealed one (1) of four (4) medication carts had expired and unlabeled insulin available for use. Observation revealed a vial of Novolog insulin was open and dated 06/20/10. Additional observation revealed a vial of Novolin R insulin was open with no date. Interview, on 07/30/10 at 12:15 PM, with Registered Nurse (RN) #2 revealed insulin was labeled and dated when open, to inform staff when to discard the insulin. In additional interview the RN stated insulin was good for sixty (60) to ninety (90) days after open. Review of the inserts in the Novolog and Novolin R insulin packets revealed the insulins should be discarded twenty-eight (28) days after opening.	F 431		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional	F 514	F 514 Resident #19 had no negative outcomes from receiving Spirolactone (medication for blood pressure) The physician was immediately notified on 7/28/10 that the resident was receiving Spirolactone 100mg PO daily and the medication was not listed on the physician order sheet for the month of July.	

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F 514	Continued From page 7 standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure the medical record was accurate and complete for two (2) of twenty (20) sampled residents (Residents #13 and #19). Resident #13's nebulizer treatments were not transcribed onto the Medication Administration Record and Resident #19 Spironolactone was not transcribed from the June to July Physician's Orders. The findings include: Observation of the medication pass, on 07/28/10 at 9:41 AM, revealed Licensed Practical Nurse (LPN) #1 administered Spirolactone (blood pressure medication) 100 mg to Resident #19. Review of the Physician's Orders for July revealed no order for the Spirolactone. Interview, on 07/30/10 at 10:05 AM, with LPN #2 revealed she had reviewed the Physician's Orders for change over from June to July. She stated she did not realize the Spirolactone was not on the July Physician's Order. She stated due	F 514	F 514 The physician wanted the resident to receive the medication during the month of July and a new order was written. Resident #13 order for Xopenex was discontinued. The physician was notified of the order transcription error and the order was discontinued due to the resident not having adverse complications. Director of Nursing and/or Licensed Nurse designee conducted a medication administration audit for random active residents on 7/30/10. Identified issues were corrected. Licensed Nursing staff was reeducated on 8/02/10 regarding monthly physician orders are accurately reflected on the Medication Administration Record. In order to ensure compliance, DON and/or designee will review new orders daily to ensure that orders are accurately recorded in the medication administration record as reflected in the physician orders. These reviews will be ongoing since it is part of the standing quality assurance review.	9/13/10

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F 514	Continued From page 8 to her failure to ensure the July orders were complete and accurate a medication error occurred. (Cross reference F 332). 2. Record review revealed Resident #13 was admitted to the facility on 07/07/10, with diagnoses which included Gastrointestinal Bleed, Urinary Tract Infection, Dehydration, Dementia, Diabetes Mellitis, Congestive Heart Failure, Coronary Artery Disease and Hypertension. Further record revealed the resident was to receive Xopenex (nebulizer treatment) every eight (8) hours beginning the day of admission. However, further review revealed the medication had not been transferred to the Medication Administration Record. Interview with the Assistant Director of Nursing, revealed the order had not been transcribed onto the physicians orders. Interview with the Assistant Director of Nursing on 07/29/10 at 5:10 PM, revealed the resident should have received the Xopenex from admission on 07/07/10 and this had been an transcription error. She stated the physician would be notified and the patient would be checked for adverse complications.	F 514	F 514 Issues identified will be corrected immediately. Results will be reviewed monthly at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring. Identified issues and recommendations will be reviewed with the Medical Director on a weekly basis.	9/13/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted on July 27, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. No deficiencies were identified during this survey.	K 000		

RECEIVED
AUG 20 2010
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator | 8/23/10

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